Complete Summary

GUIDELINE TITLE

Guidelines for the prescribing of medication for mental health disorders in people with HIV infection.

BIBLIOGRAPHIC SOURCE(S)

Royal College of Psychiatrists. Guidelines for the prescribing of medication for mental health disorders in people with HIV infection. London (UK): Royal College of Psychiatrists; 2004 Apr. 23 p. (Council report; no. CR127). [10 references]

GUIDELINE STATUS

This is the current release of the guideline.

** REGULATORY ALERT **

FDA WARNING/REGULATORY ALERT

Note from the National Guideline Clearinghouse: This guideline references a drug(s) for which important revised regulatory and/or warning information has been released.

- September 17, 2007, Haloperidol (Haldol): Johnson and Johnson and the U.S. Food and Drug Administration (FDA) informed healthcare professionals that the WARNINGS section of the prescribing information for haloperidol has been revised to include a new Cardiovascular subsection.
- May 2, 2007, Antidepressant drugs: Update to the existing black box warning on the prescribing information on all antidepressant medications to include warnings about the increased risks of suicidal thinking and behavior in young adults ages 18 to 24 years old during the first one to two months of treatment.
- October 25, 2006, Effexor (venlafaxine HCl): Published retrospective studies report that venlafaxine overdosage may be associated with an increased risk of fatal outcome.
- September 29, 2006, Lamictal (lamotrigine): New preliminary information available regarding the effects of Lamictal on the baby if taken during the first three months of pregnancy.
- August 21, 2006, Dexedrine (dextroamphetamine sulfate): Changes to the BOXED WARNING, WARNINGS and PRECAUTIONS sections of the prescribing information.
- January 13, 2006, Clozaril (clozapine) tablets: Revisions to the BOXED WARNING, WARNINGS, CONTRAINDICATIONS, PRECAUTIONS (Information for Patients and Pharmacokinetic-Related Interactions subsections), and

ADVERSE REACTIONS (Postmarketing Clinical Experience subsection) sections of the prescribing information.

- April 25, 2005, Promethazine HCl (marketed as Phenergan and generic products): Breathing problems, some causing death, have been reported when the drug was used in children less than two years old.

COMPLETE SUMMARY CONTENT

SCOPE

DISEASE/CONDITION(S)

Mental health disorders, including depression, anxiety, insomnia, and acute disturbed behavior, in people with human immunodeficiency virus (HIV) infection

GUIDELINE CATEGORY

Evaluation
Management
Treatment

CLINICAL SPECIALTY

Family Practice
Infectious Diseases
Internal Medicine
Psychiatry

INTENDED USERS

Physicians

GUIDELINE OBJECTIVE(S)

To provide guidelines for the prescribing of medication for mental health disorders in people with human immunodeficiency virus (HIV) infection

TARGET POPULATION

People with mental health disorders and concurrent human immunodeficiency virus (HIV) infection

INTERVENTIONS AND PRACTICES CONSIDERED

General Management/Assessment

1. Testing for human immunodeficiency virus (HIV) infection (with and without patient consent)
2. Patient confidentiality and disclosure of information
3. Monitoring of plasma levels of medications
4. Obtaining details of all other drugs prescribed
5. Avoiding drugs that will interact with HIV medication and those with high level of adverse effects
6. Close liaison between the HIV and mental health teams

Management of Specific Disorders

Depression

1. Selective serotonin reuptake inhibitors (SSRIs) (e.g., citalopram, sertraline, fluoxetine)
2. Other anti-depressants (e.g., mirtazapine, reboxetine, venlafaxine, sodium valproate, methylphenidate, dexamphetamine, lithium)
3. Anti-emetic agents (e.g., ondansetron)

Acute Disturbed Behaviour

1. Assessment of underlying causes of the disturbed behaviour
2. Non-pharmacological management (e.g., non-stimulating environment, closer observation)
3. Discontinuation of drugs causing neuropsychotic side effects, if possible
4. Optimisation of anti-retroviral treatment
5. Delivery of pharmacological agents (oral versus intravenous)
6. Benzodiazepines (e.g., lorazepam)
7. Other anti-psychotic medications (e.g., haloperidol, risperidone, olanzapine, quetiapine, amisulpride, clozapine)

Anxiety

1. Assessment of underlying causes and self-medication of anxiety
2. Psychological treatment
3. Antidepressants (e.g., SSRIs [citalopram, sertraline], venlafaxine)
4. Sedatives (e.g., olanzapine, mirtazapine, promethazine)

Insomnia

1. Non-pharmacological management
2. Haloperidol

MAJOR OUTCOMES CONSIDERED

- Side effects of pharmacological agents
- Drug interactions of prescribed medications
- Adherence to medication regimens
- Psychological morbidity
- Efficacy of treatments

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

Not stated

NUMBER OF SOURCE DOCUMENTS

Not stated

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Expert Consensus

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Not applicable

METHODS USED TO ANALYZE THE EVIDENCE

Review

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Not stated

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Not stated

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Not applicable

COST ANALYSIS

A formal cost analysis was not performed and published cost analyses were not reviewed.

METHOD OF GUIDELINE VALIDATION

Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

Not stated

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

Prescribing Psychotrophic Drugs for Specific Mental Health Problems

There is currently a lack of evidence for the efficacy and safety of pharmacological interventions in mental health disorders with concurrent human immunodeficiency virus (HIV) infection. The evidence available is limited to clinical trials with methodological flaws (e.g., small numbers, lack of masking, and exclusion of those with advanced HIV disease or on antiretrovirals).

Until further research is available it is impractical to adopt an evidence-based approach to prescribing psychotropic drugs for people with HIV infection. It may be more appropriate to adopt a pragmatic approach using up-to-date knowledge of pharmacology and pharmacokinetics of both psychotropic and HIV drugs. It is acknowledged that it may not be practical for psychiatrists to have a working knowledge of drugs in HIV, and that not all services include a dedicated clinical pharmacist. Therefore, these general guidance notes are designed to be used to assist in making decisions when prescribing for people with HIV infection.

Pharmacodynamic Interactions

Increased Sensitivity

Individual variation in response to medication is common. For example, in elderly people this is reflected in the use of doses of psychotropic drugs that may be one-quarter to one-half of those prescribed in younger adults. Similarly, people with HIV infection have an increased primary sensitivity even before effects secondary to other prescribed drugs are taken into account. There are a variety of reasons for this, including central nervous system infection and increased plasma concentrations resulting from a concomitant liver disease such as hepatitis C. Without adjustment of psychotropic drug dosages, those with HIV may exhibit toxicity. For example, extreme sedation and distressing extrapyramidal side-effects with haloperidol can be minimised by using an initial dose of 0.5 to 1 mg three times daily and increasing it slowly.

Additive Toxicity

Individuals with HIV are usually taking a large number of prescribed drugs; some of these may have similar pharmacological profiles, leading to additive side-effects and toxicity. These interactions may be predicted from knowledge of the pharmacological profiles and side-effects of all drugs prescribed. For example, amitriptyline prescribed for peripheral neuropathy may cause additive anticholinergic side-effects and postural hypotension when given with chlorpromazine; selective serotonin reuptake inhibitors (SSRIs) may cause intolerable nausea when prescribed with antiretrovirals that also cause nausea; additive liver toxicity may occur with concurrent use of antiretrovirals, drugs for other infections (e.g. rifampicin) and psychotropic drugs; lipodystrophy and impaired glucose metabolism due to antiretrovirals may be exacerbated by some atypical antipsychotic drugs.

Drug/Disease Interactions

Finally, it seems prudent to consider risks versus benefits and to monitor HIV infected patients carefully whenever prescribing psychotropic drugs that can cause blood dyscrasias. These include phenothiazines, lamotrigine, mianserin and, of course, clozapine.

Pharmacokinetic Interactions

Pharmacokinetic interactions relate to changes in drug absorption, displacement, metabolism, and excretion. They may be easier to predict and identify than pharmacodynamic interactions: some combinations can be avoided or doses can be increased or decreased. However, the pharmacokinetic characteristics of a drug may not be completely known even if the drug is on the market. This applies equally to very old drugs (e.g., promethazine, methylphenidate) as to newly introduced medicines. Even when the characteristics of all prescribed drugs are known, unpredictable pharmacokinetic interactions can still occur, owing to genetic polymorphisms in drug metabolising enzymes. These interactions and effects on plasma levels may directly affect intravenous drug users taking methadone. Plasma methadone levels can be reduced, with the consequent development of withdrawal symptoms and a need to increase the dose. It is important to monitor this closely because individuals may recommence illicit drug use in response to withdrawal symptoms.

Pharmacokinetic interactions mainly involve changes in drug metabolism. However, mental healthcare professionals also need to be aware that, unlike psychotropic drugs, the absorption of some HIV drugs is affected by food. For example, didanosine must be taken on an empty stomach, whereas nelfinavir must be taken with food. These requirements add to the substantial burden already placed on those having to take a large number of tablets. Psychiatrists must bear in mind the need to maintain patient motivation when adding another drug to a usually long list. Furthermore, complicated tablet regimens that do not fit into standard drug rounds on acute mental health wards will require special care and attention from in-patient nurses.

Although changes in protein binding and drug disposition have not been considered in detail, prescribers should be aware that there is the potential for drug interactions by these mechanisms. For example, weight gain or lipodystrophy can cause interactions resulting from changes in drug distribution.

Research into this area has intensified in recent years with the identification of drug metabolising enzyme systems, including the cytochrome P450 isoenzyme system. Inducers and inhibitors of specific isoenzymes have also been identified. Furthermore, there have been some small pharmacokinetic studies investigating how drug plasma levels may be affected by predicted drug interactions (e.g., following coadministration of ritonavir and fluoxetine). These developments have significantly aided the prediction of drug interactions and the subsequent alteration of doses.

Psychiatrists need to consider two further issues when prescribing for people with HIV infection. First, antiretrovirals may increase or decrease the plasma levels of psychotropic drugs. This has obvious consequences for ongoing prescribing and monitoring. Second, psychotropic drugs may increase or decrease plasma levels of antiretrovirals. This may cause toxicity or render treatment ineffective, increasing the likelihood of viral resistance. As this has public health considerations, psychiatrists are advised to avoid where possible prescribing psychotropic drugs that are known to interact with antiretrovirals and to use a suitable alternative.

Examples of drug interactions due to changes in drug metabolism include ritonavir (a strong inhibitor of CYP enzymes 3A4 and 2D6, and inducer of 1A2), which can increase levels of tricyclic antidepressants and phenothiazines 1.5- to 3-fold. This can cause unacceptable adverse events, including cardiac arrhythmias. Carbamazepine, a potent enzyme inducer, may decrease antiretroviral levels, thereby rendering therapy ineffective.

There are numerous other potential drug interactions that may or may not have clinical relevance, and giving details of these is outside the purpose of these guidelines.

Prescribing Psychotrophic Drugs for Specific Mental Health Problems in People with HIV Infection

Psychiatrists are advised to consult pharmacy services for prediction and advice on potential drug interactions in individual cases. Some general advice and guidelines on choice of psychotropic drugs in HIV are provided below, which may be amended locally as appropriate.

Guidance on Prescribing Pharmacological Treatments for Depression in HIV/Acquired Immunodeficiency Syndrome (AIDS)

There is a lack of clinical trials investigating the tolerability and efficacy of antidepressants in HIV/AIDS. The trials that are available often exclude patients taking antiretroviral drugs. There are also few data regarding the extent and the clinical relevance of pharmacokinetic interactions between antidepressants and antiretrovirals. In the absence of trial data a pragmatic approach may be taken. The choice and dose of antidepressants may be influenced by the need to minimize side-effects and the potential for pharmacokinetic interactions.

Obtain Details of all Other Drugs Prescribed

Higher doses of antidepressants may be required if the patient is receiving a potent enzyme inducer (e.g., nevirapine). Conversely, lower doses may be needed if a potent enzyme inhibitor (e.g., ritonavir) is prescribed. Advice should be sought from the pharmacy if further details are required. If the patient is taking methadone this may interact with some antidepressants. It is also important to know whether the patient is taking interferon for hepatitis C. Depression is a well recognised side-effect of this drug.

Initiate an Antidepressant With a Good Tolerability Profile and Low Potential for Interactions with Antiretrovirals and Other Prescribed Drugs

Selective serotonin reuptake inhibitors (SSRIs) are generally well tolerated and some are less likely than tricyclics to interact with antiretrovirals. The SSRIs may cause additive nausea and diarrhoea, which may result in non-adherence to medication regimens. This may be overcome by beginning the antidepressant at a low dose or co-prescription of an anti-emetic (e.g., ondansetron) for a short period. In severe cases a switch to an antidepressant with a minimal potential for nausea (e.g., mirtazapine) may be considered.

Fluoxetine inhibits several cytochrome P450 isoenzymes and therefore has the potential to increase the side-effects of drugs that are substrates for this system (e.g., efavirenz). Levels of tricyclic antidepressants may be substantially increased by some antiretrovirals, and this may cause intolerance and cardiac toxicity. Citalopram or sertraline are reasonable first-line choices. A low dose should be used initially and increased slowly. Mirtazapine has minimal potential to interact with antiretrovirals and may be a good choice if sedation is required. Mirtazapine also causes a degree of weight gain, which may be beneficial in some people. The lack of sexual side-effects may also make this drug a reasonable choice for some individuals.

Switch to Another Class of Antidepressant

There are few pharmacokinetic and tolerability data for reboxetine. Levels may be increased by some antiretrovirals. A low dose should be used initially and increased slowly; the dose should be assessed over 4-6 weeks.

Consider Drug Treatment Options for Refractory Depression

If venlafaxine is used, it should be initiated at a low dose (e.g., 37.5 mg) and increased slowly. Side-effects, which include nausea and vomiting, should be monitored. Co-prescription of indinavir should be avoided. Although its safety in HIV has not been fully elucidated, sodium valproate is still a reasonable choice of mood stabiliser. Carbamazepine should generally be avoided because of the risk of blood dyscrasias and enzyme induction. Lithium should be closely monitored in advanced AIDS if peripheral neuropathy is present and other drugs with potential renal toxicity (e.g., ganciclovir) are prescribed. Methylphenidate and dexamphetamine may be considered in specialist units but their potential for misuse must be carefully considered.

Guidance on the Rapid Control of Acute Disturbed Behaviour in Patients with HIV/AIDS and the Use of Antipsychotic Drugs

Staff on medical wards can defuse the situation by talking to the patient in a calm manner. Assessment and advice may be sought from a mental health liaison doctor or nurse on how to manage the patient without excessive use of sedative drugs. Medical wards may be busy, with one nurse for several patients: a nonstimulating environment or closer observation by a registered mental health nurse may also minimise the need for sedative medication. Staff need to be aware of the cultural context of the patient's behaviour. It is helpful if staff who speak the same language as the patient are available.

Pharmacological Management of Acute Disturbed Behaviour

Use oral medication in the first instance, and use intravenous delivery only if the patient is unable or unwilling to take oral drugs. Benzodiazepines are a suitable first-line treatment (notable exceptions include risk of respiratory depression/fluctuating consciousness and tolerance due to prior misuse). Unlike many of the other benzodiazepines, lorazepam is not metabolised by CYP3A4 and therefore one can predict that plasma levels will not be raised substantially by protease inhibitors. However, initial doses should still be one-quarter to one-half those for normal healthy adults. Lorazepam also has the advantage of a short half-life and should not accumulate on repeated administration. Antipsychotic drugs, including haloperidol, can cause unacceptable extrapyramidal side-effects. They should therefore be initiated at low doses. Long-acting preparations should be avoided. There is currently no evidence supporting the prescription of atypical antipsychotic drugs in the acute situation. Lastly, administration of antipsychotic drugs may alter the presentation of symptoms, making it difficult to assess the underlying cause of the behaviour.

Assess Underlying Causes of the Disturbed Behaviour

Many medicines used in the treatment of HIV and associated opportunistic infections have neuropsychiatric side-effects. The onset of symptoms in relation to the initiation of the suspected drug should be examined. Ideally, the offending agent should be discontinued. However, in some circumstances this may not be possible. This may be owing to unacceptable risks to the physical health of the patient, as for example when using drugs for tuberculosis. In these circumstances, side-effects should be treated symptomatically. Consideration must be given to the possibility of intoxication and of withdrawal from a variety of illicit drugs.

There are few well-designed studies evaluating the tolerability and effectiveness of antipsychotics in people with HIV infection. Treatment does not differ substantially from general psychiatry, although antipsychotic drugs may not be tolerated. Atypical antipsychotics are preferred. Clinical experience has indicated that risperidone is effective and is well tolerated at low doses. To date there is little experience with olanzapine, quetiapine, amisulpride, or clozapine. Until further studies are available psychiatrists are advised to initiate these drugs at low doses and monitor carefully. Lower starting doses of one-quarter to one-half the normal dose should be prescribed. The choice of drug should also reflect the need to avoid drug interactions.

Disturbed behaviour may be due to dementia resulting from the spread of HIV infection into the central nervous system. In this circumstance, optimisation of

antiretroviral treatment, including prescription of an agent that penetrates the central nervous system (e.g., zidovudine), should be the primary treatment plan, rather than the use of psychotropic drugs to control the disturbed behaviour.

Patients with severe and enduring mental illness will require close liaison between the HIV and mental health teams, as changes in prescription of one group of drugs may have adverse effects on the mental state or metabolism of other drugs. It is desirable that the patient collects their medication from one location, so that a complete medication profile can be maintained and adverse drug interactions rapidly identified.

Guidance on Prescribing Drugs for Anxiety and Insomnia in People with HIV Infection

Anxiety is common in those with HIV/AIDS. Treatment does not differ greatly from that given to the general population. The mainstay of therapy is psychological treatment, and there are often dedicated psychologists and psychotherapists attached to HIV specialist teams. Careful consideration should be given to prescribing any additional drugs that will add to the tablet burden. A decision to prescribe pharmacological treatment should only be made as part of a treatment plan including psychological treatments.

Assess the Underlying Cause

Anxiety is often due to difficulties in accepting the diagnosis of HIV/AIDS or related health anxiety fears. Anxiety may also be caused by the social adaptations of living with HIV, concerns about the side-effects of therapy or the ingestion of illicit substances. Continued or occasional use of illicit drugs, and dependence and withdrawal from illicit drugs and alcohol, may present with anxiety or insomnia or worsen anxiety or depression in those with comorbidity.

Enquire About Self-Medication

Many patients self-medicate to treat their anxiety with herbal medicines--Kavakava (*Piper methysticum*) is widely used--or benzodiazepines obtained from another source.

Prescribing Pharmacological Treatments for Anxiety

Benzodiazepines should be avoided if possible. In fact, it is often necessary in these situations to bring benzodiazepine intake under control. Aside from the potential for dependence, benzodiazepine prescribing can be problematic in HIV/AIDS. For example, diazepam may cause drug interactions when given concurrently with antiretrovirals. If a benzodiazepine must be used, lorazepam is the most suitable choice. This is because lorazepam has a short half-life and is not metabolised by cytochrome P450.

The SSRI antidepressants are widely prescribed and may be of some benefit. The best choices are citalopram and sertraline because they do not interact with antiretrovirals. Venlafaxine is another option, although it is necessary to increase the dose slowly to avoid side-effects.

Sedative drugs may be used as a short-term measure to control symptoms while patients gain access to psychological treatments. All of the recommendations that follow are unlicensed. Chlorpromazine is best avoided because of the high incidence of adverse effects. Olanzapine has been successfully used in a small night-time dose (2.5-5 mg). There has also been success with mirtazapine, which may be due to either the serotonergic or the sedative properties of the drug. Promethazine, a sedating antihistamine, has also been used with some success.

Prescribing Pharmacological Treatments for Insomnia

Treatment of insomnia follows similar principles as that of anxiety. However, it must be borne in mind that insomnia may be a side-effect of antiretroviral medication such as efavirenz. Individuals should be warned about this side effect before initiation of efavirenz, and consideration should also be given to the timing of doses. Many HIV centres use a low dose of haloperidol to treat efavirenz induced insomnia. However, the long-term safety of this treatment strategy has not been fully elucidated; tardive dyskinesias may occur as early as 6 months after initiation of haloperidol. If possible, insomnia should be managed without adding to the tablet burden.

The Context of Care for Mental Health Problems in People with HIV Infection

- All individuals, regardless of HIV status, should have access to appropriate care for their psychiatric disorder; such care must include the right to reasonable standards of confidentiality and their right to be consulted and asked for consent before medical proceedings, including testing for HIV infection.
- An essential component of the care of those with HIV is the provision of counselling and advice about the implications of the infection and about behaviours with low and high risk of its transmission to others. Cultural and linguistic factors need to be considered. All patients, regardless of HIV status, should be regarded as potentially at risk of transmitting and acquiring HIV infection, so that certain individuals are not singled out or dealt with in a special way. If health workers assume that all patients are at potential risk of transmitting and/or acquiring HIV infection, singling patients out as being infected is less likely to happen, so that confidentiality will be more likely to be maintained. In addition, the use of universal precautions to reduce the risk of transmission of HIV and other pathogens would be more likely to result in high standards of hygiene.
- Testing for HIV infection, like other procedures in medical and psychiatric practice, should only be carried out with an individual's informed and explicit consent, except in very rare situations. When testing is initiated by the patient, it is important to clarify with him or her the reasons for such a request and to discuss what might be gained by knowing the result and the possible adverse consequences of a positive result. Post-test counselling should also be available. In these cases, mental health workers would be well advised to liaise with staff working in genitourinary medicine and HIV clinics, and be guided by health advisors and other staff working in such settings.
- Testing for HIV may be considered for diagnostic purposes when the clinical symptoms or past history suggest HIV infection. In such cases psychiatrists should obtain informed and explicit consent for the procedure, explaining the

reasons why HIV testing has been considered and the implications of the result. Although concern about the risk of causing distress to those found to be HIV negative is sometimes suggested as a reason for not obtaining consent before the test, it is important to consider the problems likely to arise when an unprepared person, unaware of the procedure being carried out, has to be informed of positive HIV test results.

- Testing for HIV infection without explicit consent is permissible only in exceptional circumstances (General Medical Council, 1997), for example if testing would be in the clinical interest of an unconscious patient or if, during their work, health workers or others have been exposed to the blood or body fluids of a patient and prophylactic treatment may be available if the patient's HIV status is established. In psychiatric practice the issue of testing without consent is likely to arise in cases where, as a result of psychiatric illness, the individual is either unwilling to give consent or unable to do so. Psychiatrists are familiar with these issues in the context of the Mental Health Act 1983, but the provisions of the Act do not cover all the possible problems arising in relation to HIV infection. Faced with the question of testing without the individual's consent, psychiatrists should ensure that the reasons for testing are clearly established, in particular in what way the treatment would be influenced by knowledge of HIV status, what benefit to the individual would be expected and the extent to which it would ensure the safety of staff or other patients; it should also be considered whether such safety could be achieved in the absence of knowledge of the HIV test result. A decision to test without consent should only be reached after discussion with the rest of the clinical team, ideally in consultation with a physician with experience of HIV disease and possibly after obtaining legal advice.
- Patients with HIV, like any other patients, have the right to expect reasonable standards of confidentiality regarding their health. Patients are usually treated by a clinical team rather than by a single individual and the question of disclosure of HIV status to team members will arise. Patients should be made aware of the importance of ensuring that professionals involved in a patient's care are aware of his or her health and potential difficulties. The patient's agreement should be obtained if others are to be informed of his or her HIV status. If patients refuse to allow other health workers to be informed, their wishes must be respected except where failure to disclose information puts a healthcare worker or other patients at serious risk of death or serious harm (General Medical Council, 1997). Disclosure of information to close contacts or relatives may occur in order to protect a person from risk of death or serious harm (General Medical Council, 1997). In all these cases of disclosure to others, psychiatrists should ensure that the patient is aware of the steps being taken to inform the third party.

CLINICAL ALGORITHM(S)

None provided

EVIDENCE SUPPORTING THE RECOMMENDATIONS

REFERENCES SUPPORTING THE RECOMMENDATIONS

References open in a new window

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of evidence supporting the recommendations is not specifically stated.

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

Appropriate treatment of specific mental health problems in people with human immunodeficiency virus (HIV) infection, to minimize adverse effects of treatment and drug interactions

POTENTIAL HARMS

- Side effects of prescribed medications
- Interactions of prescribed medications

See "Major Recommendations" field and original guideline document for information about side effects and interactions of specific drugs.

CONTRAINDICATIONS

CONTRAINDICATIONS

Table 1 in the original guideline document lists drugs to be avoided during antiviral treatment on the basis of pharmacokinetic considerations.

QUALIFYING STATEMENTS

QUALIFYING STATEMENTS

Until further research is available it is impractical to adopt an evidence-based approach to prescribing psychotropic drugs for people with human immunodeficiency virus (HIV) infection. It may be more appropriate to adopt a pragmatic approach using up-to-date knowledge of pharmacology and pharmacokinetics of both psychotropic and HIV drugs. It is acknowledged that it may not be practical for psychiatrists to have a working knowledge of drugs in HIV, and that not all services include a dedicated clinical pharmacist. Therefore, these general guidance notes are designed to be used to assist in making decisions when prescribing for people with HIV infection.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

An implementation strategy was not provided.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Getting Better
Living with Illness

IOM DOMAIN

Effectiveness
Patient-centeredness
Safety

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

Royal College of Psychiatrists. Guidelines for the prescribing of medication for mental health disorders in people with HIV infection. London (UK): Royal College of Psychiatrists; 2004 Apr. 23 p. (Council report; no. CR127). [10 references]

ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

2004 Apr

GUIDELINE DEVELOPER(S)

Royal College of Psychiatrists - Medical Specialty Society

SOURCE(S) OF FUNDING

Royal College of Psychiatrists

GUIDELINE COMMITTEE

The Royal College of Psychiatrists Working Party

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

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FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

Not stated

GUIDELINE STATUS

This is the current release of the guideline.

GUIDELINE AVAILABILITY

Electronic copies: Available in Portable Document Format (PDF) from the Royal College of Psychiatrists Web site.

Print copies: Available from the Royal College of Psychiatrists, 17 Belgrave Square, London SW1X 8PG

AVAILABILITY OF COMPANION DOCUMENTS

None available

PATIENT RESOURCES

None available

NGC STATUS

This NGC summary was completed by ECRI on January 10, 2006. This summary was updated by ECRI on September 7, 2006 following the updated U.S. Food and Drug Administration advisory on Dexedrine. This summary was updated by ECRI on November 16, 2006, following the FDA advisory on Lamictal (lamotrigine). This summary was updated by ECRI on November 22, 2006, following the FDA advisory on Effexor (venlafaxine HCl). This summary was updated by ECRI Institute on October 2, 2007, following the U.S. Food and Drug Administration (FDA) advisory on Haloperidol. This summary was updated by ECRI Institute on November 9, 2007, following the U.S. Food and Drug Administration advisory on Antidepressant drugs.

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